



HEALTH PROFESSIONS EDUCATION LOAN REPAYMENT PROGRAM APPLICATION

TO BE COMPLETED BY APPLICANT:

Please type or print clearly and legibly.

SECTION I - PERSONAL DATA

NAME: _____
FIRST MIDDLE LAST

MAILING ADDRESS: _____
STREET/P.O. BOX APARTMENT #

CITY STATE COUNTY (required) ZIP CODE

PERMANENT ADDRESS: _____
STREET/P.O. BOX APARTMENT #

CITY STATE COUNTY (required) ZIP CODE

HOME PHONE: () _____ WORK PHONE: () _____

E-MAIL ADDRESS: _____ CALIFORNIA DRIVER'S LICENSE/I.D. #: _____

SOCIAL SECURITY NUMBER: _____ BIRTH DATE: _____

SEX: ☐ MALE ☐ FEMALE ARE YOU A U.S.CITIZEN/PERMANENT RESIDENT? ☐ YES ☐ NO

ARE YOU A CALIFORNIA RESIDENT? ☐ YES ☐ NO

ARE YOU CURRENTLY UNDER ANY CONTRACT WITH THE FOUNDATION? ☐ YES CONTRACT # _____ ☐ NO

PLEASE PROVIDE THE NAME OF YOUR CALIFORNIA STATE SENATOR AND CALIFORNIA STATE ASSEMBLY MEMBER.

STATE STATE
SENATOR: _____ ASSEMBLY MEMBER: _____

PLEASE INDICATE WHERE YOU RECEIVED YOUR APPLICATION:

☐ SCHOOL ☐ INTERNET ☐ FOUNDATION OFFICE
☐ OTHER (PLEASE SPECIFY) _____

PLEASE INDICATE YOUR ETHNIC BACKGROUND:

☐ African American ☐ Hispanic American ☐ Caucasian ☐ Other (Please Specify) _____
☐ Native American (Please Specify Tribal Affiliation and "Portion") _____

In addition to English, list any other languages you speak, read, or write fluently: _____



HEALTH PROFESSIONS EDUCATION LOAN REPAYMENT PROGRAM EMPLOYMENT VERIFICATION FORM

(THIS FORM MUST BE COMPLETED BY AN OFFICIAL IN THE PERSONNEL OR HUMAN RESOURCES DEPARTMENT)

SECTION II QUALIFYING PRACTICE LOCATION

EMPLOYEE NAME: _____

DATE OF HIRE: _____

POSITION TITLE: _____

MONTHLY SALARY: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY

STATE

ZIP CODE

EMPLOYEE'S MANAGER: _____ TITLE: _____

TELEPHONE #: _____

Please certify that the employee works a minimum of 32 hours per week to qualify for this program. ☐ Yes ☐ No

ADDITIONAL COMMENTS:

THIS FORM WAS COMPLETED BY:

NAME: _____

TITLE: _____

TELEPHONE: _____

SIGNATURE: _____ DATE: _____

PLEASE ANSWER ALL QUESTIONS IN THE SPACE PROVIDED (DO NOT ATTACH ESSAYS).

SECTION III – EDUCATION AND PROGRAM ELIGIBILITY

Program Enrolled: ☐ Dentistry ☐ Dental Hygiene ☐ Nurse Practitioner ☐ Nurse Midwifery ☐ Physician Assistant

NAME OF SCHOOL: _____

SCHOOL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PROGRAM DIRECTOR: _____ PHONE: () _____

Have you or will you have a degree in the specialty identified above by June 2001?

☐ YES ☐ NO (If no, you are ineligible)

ARE YOU CURRENTLY EMPLOYED AS A LICENSED HEALTH CARE PROVIDER IN CALIFORNIA? ☐ YES ☐ NO

If yes , please provide license # _____ Expiration Date: _____

SECTION IV – PERSONAL BACKGROUND

A. DESCRIBE YOUR CAREER GOALS

What kind of work would you like to do immediately after graduation?

What kind of work do you think you'll be doing in five years?

What is your vision of your professional future in ten years?

SECTION IV – PERSONAL BACKGROUND cont.

B. LIST YOUR EMPLOYMENT HISTORY FOR THE PAST 10 YEARS

Dates (Mo/Yr – Mo/Yr)	Hours/Week	Position	Employer	City, State	Description of responsibilities

C. List any community service or professional activities within the past two years. Include work with community-based organizations, student organizations, civic committees, political associations, or religious organizations. At least one of the two required letters of recommendations should come from an individual who is qualified to verify and assess one of the community and/or professional activities listed below. **Do not include experience for which you received academic credit.**

Dates (Mo/Yr – Mo/Yr)	Hours/Week	Position	Organization	City, State	Description of responsibilities

D. BACKGROUND**Residence History**

Years	City, County, State	Specify if Rural, Urban, Suburban, Reservation, Inner City, etc...	Socioeconomic Level (Poor, Middle-class, etc...)	Predominant Ethnic Group in Community (White, Hispanic, African American etc...)
Birth - 10				
10 – 20				
20 – 30				
30 - 40				
40 - Current				

DESCRIBE YOUR FAMILY STRUCTURE, ANY ADVERSE FAMILY CIRCUMSTANCES, AND CHALLENGES.

HOW IS YOUR BACKGROUND RELEVANT TO YOUR INTEREST IN PURSUING A CAREER IN THIS FIELD OF STUDY?

SECTION V A. - EDUCATIONAL DEBT

- List source and amounts of outstanding educational loans used to finance your education on the table below.
- List the school you were attending and the attendance period for which you obtained the loan (e.g. CSU san Diego, 1991/1992), the lender's name, address, and type of loan program, the loan ID number, and the outstanding balance.
- The most typical student loans include Perkins (formerly NDSL) and Nursing Student Loans (SLS) which are obtained through private lending institutions. Many colleges and universities have their own loan programs.

YOU MUST SUBMIT EVIDENCE OF THE EDUCATIONAL DEBTS LISTED BELOW. (i.e. Current statements for referenced accounts.)

✦ List other loans on a separate sheet and attach to the application ✦

1	School Attended		Loan Period			
	Lending Institution		Loan Program		Outstanding Balance	\$
	Lender's Address		Loan ID#		Monthly Payment	\$

2	School Attended		Loan Period			
	Lending Institution		Loan Program		Outstanding Balance	\$
	Lender's Address		Loan ID#		Monthly Payment	\$

3	School Attended		Loan Period			
	Lending Institution		Loan Program		Outstanding Balance	\$
	Lender's Address		Loan ID#		Monthly Payment	\$

SECTION V B. – EXPENSES –vs- INCOME

Applicant's marital status: ☐ Married ☐ Unmarried Number of dependents other than self and spouse: _____ Age of dependents: _____

List expenses and resources for the current calendar year:

Applicant's Expenses:

Housing/Rent _____
Homeowner's /renter's insurance _____
Utilities (Telephone, etc.) _____
Automobile Payments _____
Transportation Expenses (gasoline/maintenance) _____
Food/meals _____
Uncovered Medical Expenses _____
Clothing _____
Child care expenses _____
Miscellaneous personal (explain) _____

Total Expenses \$ _____

Applicant's and spouses adjusted income _____
Applicant's and spouses untaxed income _____
Spousal/child support received _____
Benefits _____
Other income (list explain) _____

Total - Resources \$ _____

Below, please provide any needed explanation for the above items or additional information that supports your need for loan repayment.

CHECKLIST: DID YOU INCLUDE?

- _____ ALL SECTIONS (Pages 1-7) OF THE APPLICATION
- _____ EMPLOYMENT VERIFICATION FORM – **COMPLETED BY PERSONNEL/HUMAN RESOURCES OFFICER**
- _____ **OFFICIAL** COLLEGE TRANSCRIPTS (AS STATED IN THE "APPLICATION REQUIREMENTS")
- _____ DOCUMENTATION OF THE EDUCATIONAL DEBT(S) LISTED & LENDER STATEMENT(S)
- _____ 2 ORIGINAL LETTERS OF RECOMMENDATION ON LETTERHEAD (AS STATED IN THE "APPLICATION REQUIREMENTS")
- _____ 2000 TAX RETURNS ALONG WITH W-2S AND/OR 1099S

NOTE: IT IS THE RESPONSIBILITY OF THE APPLICANT TO CONTACT THE FOUNDATION OFFICE BY 5:00 P.M. ON THE FINAL FILING DATE AT (800) 773-1669 TO VERIFY WHETHER HIS/HERS APPLICATION WAS RECEIVED COMPLETE AND ACCURATE. THE FOUNDATION WILL NOT PLACE CALLS TO REQUEST ADDITIONAL INFORMATION OR CLARIFY ANY INFORMATION PROVIDED. IF AN INQUIRY IS MADE BY THE APPLICANT WHEREIN THE APPLICANT IS INFORMED THAT HIS/HER APPLICATION WAS INCOMPLETE, THE APPLICANT WILL HAVE 5 BUSINESS DAYS TO SUBMIT ORIGINAL VERSIONS OF ALL DOCUMENTS REQUIRED TO COMPLETE THE APPLICATION (COPIES AND FAXES WILL NOT BE ACCEPTED).

AND

PLEASE REMEMBER TO DUPLICATE APPLICATIONS PRIOR TO SUBMISSION. THE FOUNDATION WILL NOT RETURN ANY ORIGINALS OR COPIES OF THE APPLICATION PACKET.

I certify that all statements in this application are complete and accurate. I also authorize the Foundation to verify any information included on the application form and/or the attachments submitted with the application. I understand that falsification or discrepancies in documentation submitted will disqualify my application and the appropriate licensing board will be notified.

Signature: _____ Date: _____

INCOMPLETE OR LATE APPLICATION PACKETS WILL NOT BE EVALUATED

RETURN APPLICATION TO:
HEALTH PROFESSIONS EDUCATION FOUNDATION
1600 9th Street, Suite 436
Sacramento, CA 95814

FOR OFFICE USE ONLY

COMPLETE: YES _____ NO _____ IF NO, STATE REASON _____

RECEIVED BY: _____ (initials)